

KAMS Diphtheria Guidance

1. Policy Statement

Staff should refer to the [WA diphtheria outbreak case and contact management interim guidance](#) and [CDNA Interim guidance for diphtheria outbreak management](#) for the most current principles and actions regarding case definitions. The state and national guidance outlines the key response actions and principles for interventions during diphtheria outbreaks to ensure consistency in identifying confirmed, probable, and suspected case. The KAMS document includes guidance on internal management that aligns with Kimberley Population Health Unit advice, and State and CDNA guidelines.

Certain criteria within this document is subject to change depending on the outbreak level. Please routinely check for updates and avoid printing.

Key update section 30/6/26

Antibiotic treatment of cases and chemoprophylaxis for contacts

- Addition of amoxicillin as an alternative antibiotic for people with contraindications to azithromycin (e.g. long QT)

Case management

- Addition of clearance testing option for cases with respiratory diphtheria receiving single high-dose azithromycin (test at least 5 days after receiving single high-dose azithromycin).

Contact management

- Addition of advice to wait for notification from KPHU confirming a toxigenic positive diphtheria case before commencing contact tracing and treatment.
- Advice about re-exposure of contacts while on chemoprophylaxis.

2. Procedures

The following sections outline the process of management of Diphtheria cases and contacts.

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Notification Processes

Notifications of new cases will come through the Kimberley Population Health Unit (KPHU).

- KPHU will notify the relevant **Clinic Manager** and **Infection Prevention and Control personnel**.
- Staff receiving the notification from KPHU must notify via email:
 - Medical Director
 - Remotes Executive Manager
 - Senior Medical Officer
 - Public Health Registrar

Management of Suspected and Confirmed Cases

Staff caring for suspected or confirmed cases of diphtheria should adhere to standard, contact and droplet precautions until 72 hours of antibiotic treatment completed. This includes donning PPE for close contact and wound care, including wearing:

- Gloves
- Gowns
- Surgical mask
- Eyewear

Additionally:

- For patients with cutaneous diphtheria ensure wounds are covered with waterproof, occlusive dressing.
- For all patients presenting to the clinic with suspected or confirmed diphtheria, ask them to wear a surgical mask.
- All cases should be advised to avoid contact where possible with people beyond their household at least for the duration of their antibiotic course.
- Provide all confirmed and suspected cases with a [Factsheet](#).
- Utilise isolation room.

For further guidance on PPE and Cleaning refer to: DOC_2147 [KAMS Standard and Transmission Based Precaution Guideline](#).

For signage: [Standard and Transmission Based Precautions Signage](#).

Complete [Contact Tracing](#) and [Treatment Protocol](#) for each case as detailed below.

VISITOR RESTRICTIONS MAY BE IN PLACE

For all staff

Contact precautions

In addition to standard precautions

Before entering room/care zone

- 1 Perform hand hygiene
- 2 Put on a gown
- 3 Wear gloves, in accordance with standard precautions

At doorway prior to leaving room/care zone

- 1 Remove and dispose of gloves if worn
- 2 Perform hand hygiene
- 3 Remove and dispose of gown
- 4 Leave the room/care zone
- 5 Perform hand hygiene

What else can you do to stop the spread of infections?

- Always change gloves and perform hand hygiene between different care activities and when gloves become soiled to prevent cross contamination of body sites
- Consider patient placement
- Minimise patient movement

Always use standard precautions

- Perform hand hygiene before and after touching a patient or their surroundings
- Use personal protective equipment (PPE)*
- Use respiratory hygiene and cough etiquette

- Use aseptic technique
- Use and dispose of sharps safely
- Perform routine environmental cleaning and maintain a clean and safe healthcare environment

- Clean and reprocess reusable patient equipment
- Handle and dispose of waste safely
- Handle and dispose of used linen safely

*When used as part of **standard precautions**, PPE protects against probable exposure to blood and body substances. When used as part of **transmission-based precautions**, PPE serves as a barrier to specific means of transmission of infectious agents.

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VISITOR RESTRICTIONS MAY BE IN PLACE

For all staff

Droplet precautions

In addition to standard precautions

Before entering room/care zone

- 1 Perform hand hygiene
- 2 Put on surgical mask
- 3 Put on protective eyewear
- 4 Perform hand hygiene

At doorway prior to leaving room/care zone

- 1 Perform hand hygiene
- 2 Remove protective eyewear
- 3 Perform hand hygiene
- 4 Remove mask and dispose of mask
- 5 Leave the room/care zone
- 6 Perform hand hygiene

What else can you do to stop the spread of infections?

- Consider patient placement
- Minimise patient movement
- Appropriate bed allocation.

Always use standard precautions

- Perform hand hygiene before and after touching a patient or their surroundings
- Use personal protective equipment (PPE)*
- Use respiratory hygiene and cough etiquette

- Use aseptic technique
- Use and dispose of sharps safely
- Perform routine environmental cleaning and maintain a clean and safe healthcare environment

- Clean and reprocess reusable patient equipment
- Handle and dispose of waste safely
- Handle and dispose of used linen safely

*When used as part of **standard precautions**, PPE protects against probable exposure to blood and body substances. When used as part of **transmission-based precautions**, PPE serves as a barrier to specific means of transmission of infectious agents.

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Documentation for tracking

Ensure the patient has been documented as a 'Diphtheria' or 'Diphtheria close contact' case using the Infectious Status drop down in progress notes. This allows for MMEx reports on current cases and close contacts.

New Progress Note

Save New Note Clinical Handover Record

Privacy Level: Visible To All Date: 07/04/2025 12:20 pm

Reason For Contact: Dialysis Session

Precautions: Select One

Infectious Status: Select One

COVID-19 Status: Select One

To run a report on the flagged cases:

1. Navigate to Forms and Reports
2. Click 'Person Contact via Progress Notes'
3. In 'Filters' sections ensure under 'Users' that 'All' is selected
4. Enter in relevant dates
5. Select 'Columns'
6. Unselect categories not required for report
7. Click search
8. Export to excel for data cleaning

Example:

Person Contact Report

Query Templates New Query ...

Filters Columns

Start Date 01/04/2026 End Date 28/04/2026

User All

Status All

Search Save Search As New

Person Contact Report

Query Templates New Query ...

Filters Columns

☐ Select All

☒ Patient ☒ DOB ☒ Age ☒ ATSI ☒ Sex ☐ Date Referred ☐ Date Of First Contact ☐ Date Of Session One

☐ Number Of Sessions ☒ Staff Member ☐ Active ☐ Inactive Date ☐ Number Of Sessions In Time Frame ☐ Date Of First Sessions In Time Frame ☐ Date Of Last Sessions In Time Frame ☐ Reason For Contact

☒ Precautions ☒ Infection Status ☐ COVID-19 Status

Search Save Search As New

Testing

- Suspect respiratory diphtheria in cases of exudative tonsillitis, or those who are very unwell with fever, enlarged cervical lymph nodes and upper respiratory tract infection symptoms.
 - For those with respiratory symptoms, also take POCT for Strep A
- Suspect cutaneous diphtheria in cases with slow healing or non-healing wounds, or wounds that appear punched out with a blue/grey tinge.
- **Alert the senior GP before testing for diphtheria – antibiotics should be commenced for symptomatic patients prior to receiving results.**

Swabs

- Two swabs need to be collected for throat and/or wound swabs (see below)
 - 1. Semi-solid transport medium swab (Amise) with or without charcoal (black top) for **diphtheria culture**
 - 2. Paired PCR dry swab (orange top) for **direct PCR toxin testing**
- If you suspect cutaneous diphtheria you must ALSO take a throat swab for diphtheria.
- Ensure you **free text 'culture and PCR for diphtheria'** on the pathology request form.
- The results will return in 2 stages: the PCR result will show presence of diphtheria toxin gene; the second MC+S result will show growth of *C Diphtheriae* or *C Ulcerans* bacteria.
- If you need to order additional supplies of dry or charcoal swabs, please order directly through PathWest's [Clinic Supply Order Form](#).



Charcoal swab



Dry swab

Request should look like:

Tests Required

Add a test from the picker below [Manage Templates...](#)

+ Add Custom Test
 📄 Import Overdue and Pending Care Plan Activities

Test Name	Specimen Site	
Culture for diphtheria	Throat and/or wound	Remove
PCR for diphtheria	Throat and/or wound	Remove

Treatment

There are two pathways for **toxigenic positive diphtheria** treatment, based on type of infection (respiratory versus cutaneous). Treatment of confirmed cases and contacts is in accordance with the WA diphtheria outbreak case and contact management interim guidance and [e-Therapeutic Guidelines](#). Treatment of **toxigenic negative diphtheria** is also included below.

Confirmed Respiratory Diphtheria Toxigenic Positive

If you are suspecting respiratory diphtheria in a symptomatic patient, commence antibiotic treatment EARLY. Do not wait for the results of the swabs as there can be a delay.

Respiratory Diphtheria Toxigenic POSITIVE	
Alert	- Alert the Senior GP on-call for management guidance for all respiratory diphtheria - Issue URGENT patient recall
Treatment	- If the patient is clinically stable and can safely swallow, prescribe: - PO Azithromycin 500mg (child: 10mg/kg up to 500mg) once daily for 7 days - The standard multi-day regime is strongly recommended, however a single high-dose of azithromycin may be considered if there are significant barriers to adherence to oral therapy: - Single high-dose oral azithromycin 2g (child: 30mg/kg up to 2g) - If there are contraindications to azithromycin, consider alternative treatment options as per eTG – Diphtheria or discuss with an infectious diseases physician or clinical microbiologist. - E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days - Ensure appropriate treatment of other organisms consistent with the clinical presentation (e.g. streptococcal throat infections) - If the patient is clinically unstable or at risk of airway compromise (significant neck swelling, presence of a pseudomembrane in the throat, difficulty breathing, signs of sepsis), they will require transfer out of community for respiratory support and consideration of Diphtheria Anti-Toxin (DAT) - Commence IV Benzylpenicillin 1.2g (child: 50mg/kg up to 1.2g) 6 hourly + IV Azithromycin 500mg (child: 10mg/kg up to 500mg) daily - All severe cases also require an ECG, IV lines, Chem 8/CG4+, blood cultures and baseline neurological and cranial nerve examination.
Contact tracing	Begin contact tracing for all contacts in previous 72 hours before symptom onset for all confirmed diphtheria on MC+S swab. <u>Do not wait for toxigenic report</u> as this will delay contact tracing. See <i>Contact tracing</i> page 8-10.
Follow-up	If the patient remains in community, provide daily clinical check-in, either via home visit or telephone.
Isolation and clearance	Cases should be excluded from work, school and childcare until they have completed antibiotics.

	- Where possible, clearance testing of respiratory cases with repeat throat MC+S and PCR swabs should be taken 24 hours after completion of antibiotics (or at least 5 days after receiving single high-dose azithromycin). - it is recognised that this may be difficult in an outbreak setting. In this circumstance, cases who attend high-risk settings (e.g. school, childcare, healthcare workers, prisons) should be prioritised - if microbiological clearance by negative throat culture is not achieved (where performed), consult with an infectious disease physician or clinical microbiologist for advice about further antibiotics. Cases should be advised to stay at home and minimise contact with the community until antibiotic treatment is complete.
Vaccination	Give a booster dose of dTpa if greater than 12 months since last dose when case is recovering from acute illness. Liaise with the Senior GP regarding timing of this.

Confirmed Cutaneous Diphtheria Toxigenic Positive

If you are suspecting cutaneous diphtheria in a symptomatic patient, commence antibiotic treatment EARLY. Do not wait for the results of the swabs as there can be a delay.

Cutaneous Diphtheria Toxigenic POSITIVE	
Alert	- Alert the Senior GP on-call for management guidance for all cutaneous diphtheria - Issue URGENT patient recall
Treatment	- Cover wound with occlusive water proof dressing - Prescribe - PO Azithromycin 500mg (child: 10mg/kg up to 500mg) once daily for 7 days - The standard multi-day regime is strongly recommended, however a single high-dose of azithromycin may be considered if there are significant barriers to adherence to oral therapy: - Single high-dose oral azithromycin 2g (child: 30mg/kg up to 2g) - If there are contraindications to azithromycin, consider alternative treatment options as per eTG – Diphtheria or discuss with an infectious diseases physician or clinical microbiologist. - E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days - Ensure appropriate treatment of other organisms consistent with the clinical presentation (e.g. identified on wound swabs - <i>Staphylococcus</i> and <i>Streptococcus</i> are frequently co-isolated)
Contact tracing	Begin contact tracing for all contacts in previous 72 hours of symptom onset for all confirmed diphtheria on MC+S swab. <u>Do not wait for toxigenic report</u> as this will delay contact tracing. See <i>Contact tracing</i> page 8-10.

Follow-up	If the patient remains in community, provide regular clinical check-in, either via home visit or telephone.
Isolation and clearance	- Cases should be excluded from work, school and childcare until they have completed 72 hours of antibiotics - Clearance testing is <u>not</u> required for cutaneous diphtheria
Vaccination	Give a booster dose of dTpa if greater than 12 months since last dose when case is recovering from acute illness. Liaise with the Senior GP regarding timing of this.

Diphtheria toxigenic **NEGATIVE** (respiratory and cutaneous)

If the diphtheria culture returns toxigenic **NEGATIVE**, antibiotics can be ceased, contact tracing can be ceased and no further case management or isolation is required.

Transfer out of Community

Follow usual protocols for transfer out of community based on acuity. Severe Diphtheria will need transfer to Broome Regional Hospital for anti-tox medication.

- If the patient is clinically unstable or at risk of airway compromise (significant neck swelling, presence of a pseudomembrane in the throat, difficulty breathing, signs of sepsis), they will require transfer out of community for respiratory support and consideration of Diphtheria Anti-Toxin (DAT)
 - Whilst awaiting transfer commence IV Benzylpenicillin 1.2g (child: 50mg/kg up to 1.2g) 6 hourly + IV Azithromycin 500mg (child: 10mg/kg up to 500mg) daily

ETS Script

Ensure that the ETS script includes context that the Kimberley region is currently experiencing a diphtheria outbreak and that if there is clinical or epidemiological suspicion of diphtheria, the closest anti-tox medication is at Broome Regional Hospital.

Clearance of Cases

Where possible, mild cases should undergo clearance testing with at least one negative throat swab taken at least 24 hours after completing antibiotics (or at least 5 days after receiving single high dose azithromycin):

- it is recognised that this may be difficult in an outbreak setting. In this circumstance, cases who attend high-risk settings (e.g. school, childcare, healthcare workers, prisons) should be prioritised
- if microbiological clearance by negative throat culture is not achieved (where performed), consult with an infectious disease physician or clinical microbiologist for advice about further antibiotics.
- Cases should be advised to stay at home and minimise contact with the community until antibiotic treatment is complete.**

Contact tracing:

- Wait for advice from KPHU confirming a toxigenic positive diphtheria case before commencing contact tracing and treatment.

- Take a contact tracing history from the patient and/or guardian for all contacts in the last 7 days.
- Attend the positive cases home to take a contact tracing history.
This helps prevent spread in the clinic and can give an idea of household contacts.
- Each contact will be classified as HIGH, MEDIUM or LOW risk, depending on their exposure.
[Please see Table 1.](#)
 - The risk category will determine the management.
- Please use the KPHU form emailed to clinics to document contact tracing
- All spreadsheets must be sent to IPC+C (emma.martinskis@kamsc.org.au) who will forward onto KPHU
- See [Appendix 3](#) for AHCWA patient facing resources for contact tracing.

Table 1: Close contact risk stratification.

Risk category	Contact Tracing Criteria Respiratory	Contact Tracing Criteria Cutaneous
HIGH	Household contact Close travel contact Intimate partner Close range respiratory exposure – direct exposure of mucous membranes to respiratory secretions or droplets (e.g. being coughed or sneezed on at close range) or sharing utensils, drinks. Healthcare worker - direct unprotected exposure to respiratory secretions (swabbing or examining throat without PPE, resuscitation).	Household contact or intimate partner and had direct contact with skin lesions, dressings or contaminated items (towels/bedding) Direct exposure to infected wound without appropriate PPE.
MEDIUM	Close contact in shared indoor space ≥8 hours (e.g. classroom, childcare) with no direct secretion/droplet exposure Healthcare worker contact without appropriate PPE, but no direct secretion exposure or uncertain level of exposure.	Indirect prolonged exposure ≥20 hours cumulative when wound uncovered e.g. shared living space, childcare. Healthcare worker contact with wound without appropriate PPE, but no risk of droplet generation during contact or uncertain level of exposure.
LOW	Casual or indirect contact (e.g. same school or workplace without close exposure) Healthcare workers no exposure to respiratory droplets nor direct contact with respiratory secretions.	Casual or indirect contact (e.g. same school or workplace without close exposure) Healthcare workers no direct exposure to skin lesions or wound droplets.

Management of Contacts

Repeat exposure: is a contact is re-exposed to a confirmed toxigenic positive diphtheria while receiving (or within 3 days of completing) azithromycin chemoprophylaxis, no additional course is required. Re-exposure after this period requires re-assessment of risk.

HIGH Risk Contacts

- Take a **throat and cutaneous swab** if contacts are symptomatic or lesions are present. Asymptomatic contacts do not need to be tested, **if** they are provided with chemoprophylaxis +/- booster vaccination, but may be considered if the contact attends high-risk locations i.e. healthcare facility, school, childcare
 - Specify 'diphtheria culture' and 'diphtheria close contact' on the pathology form
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 12 months
 - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.
- Symptomatic contacts: give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 7 days as **presumed treatment**.
- Asymptomatic contacts: give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 5 days as **prophylactic antibiotics**.
- The standard multi-day regimen of azithromycin is strongly recommended, however a single high-dose azithromycin may be considered where there are significant barriers to adherence to oral antibiotics: azithromycin 2g orally as a single dose (child: 30mg/kg up to 2g)
- If there are contraindications to azithromycin, consider alternative treatment options as per [eTG – Diphtheria](#) or discuss with an infectious diseases physician or clinical microbiologist.
 - E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days
- Where possible, avoid contact with vulnerable populations (e.g. elderly, immunocompromised, young infants). Healthcare workers should not return to work until completion of 72 hours of antibiotics or when returned a negative test
- Advise to monitor for symptoms for 7 days.

MEDIUM Risk Contacts

- Take a **throat and cutaneous swab** if contacts are symptomatic or lesions are present. Asymptomatic contacts do not need to be tested, **if** they are provided with chemoprophylaxis +/- booster vaccination, but may be considered if the contact attends high-risk locations i.e. healthcare facility, school, childcare
 - Specify 'diphtheria culture' and 'diphtheria close contact' on the pathology form
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 12 months
 - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.
- Give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 5 days as **prophylactic antibiotics**.

- The standard multi-day regimen of azithromycin is strongly recommended, however a single high-dose azithromycin may be considered where there are significant barriers to adherence to oral antibiotics: azithromycin 2g orally as a single dose (child: 30mg/kg up to 2g)
- If there are contraindications to azithromycin, consider alternative treatment options as per [eTG – Diphtheria](#) or discuss with an infectious diseases physician or clinical microbiologist.
 - E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days
- Healthcare workers should wear a mask at work until completion of 72 hours of antibiotics or when returned a negative test
- Advise to monitor for symptoms for 7 days.

LOW Risk Contacts

- Advise to monitor for symptoms for 7 days.
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 5 years
 - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.

Vaccination of the Community

Vaccination criteria is subject to change depending on the outbreak level. Please routinely check for updates to this section via LogiQC Doc_4375.

Main points:	• Opportunistically offer vaccination check to any community member attending the clinic. • Encourage cases or close contacts to talk to people about the vaccine and attend the clinic to check their status if they are worried. • Use Boostrix or Adacel for vaccination to cover for pertussis booster.
Community	• Offer booster dTpa vaccine if 5 years or more since last dose for Aboriginal adult patients • Actively recall any patient who has not completed primary course or is due a dTpa vaccine as per the WA Health Immunisation Schedule
Cases	• Vaccinate with dTpa vaccine if 1 year or more since last dose once starting to recover from acute infection
Close contacts	• Vaccinate high risk and medium risk close contacts if it has been over 1 year since last dTpa vaccine
Health care workers	• Recommend booster dTpa vaccine if 5 years or more since last dose <i>as per WA Health Immunisation Schedule update 30 April 2026</i>

Non-Aboriginal patients	• Non-Aboriginal patients living in the Kimberley are eligible for a booster dTpa vaccine if 5 years or more since last dose as <i>per WA Health Immunisation Schedule update 30 April 2026</i> • Eligible for free vaccine if HCW or pregnant or have not completed primary course as per WA Health Immunisation Schedule
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Vaccinator Parameters

For Nurses, Midwives, AHPs, AHWs to maintain practice within the immunisation SASA – any vaccine given outside of the current WA Immunisation Schedule should be prescribed by a member of the medical team. **Contact an onsite or on-call GP for prescribing a diphtheria containing vaccine if not within WA Immunisation Schedule criteria.**

Vaccine Competency

All staff providing vaccinations should be up to date with the 2026 Vaccine Update and Cold Chain training on the WA Health Rise platform to meet criteria for administering the dTpa vaccines under a SASA if this becomes available.

Link to training: <https://immunisation-education.reach360.com/learn/my-learning>

Vaccine Ordering

Ensure adequate stock of Boostrix and Adacel at clinic level, aim for 50 vaccinations.

Vaccination Clinicians will be contacting clinics to keep current stock levels updated to ensure rapid re-stocking available if required.

Outbreak Support

KAMS has stood up an Outbreak Management Team (OMT) in response to the outbreak.

- If you require resources or clinical support, please reach out to the Public Health Registrar at carla.deangelis@kamsc.org.au
- If you require support with vaccines, please email vaccinesupport@kamsc.org.au
- If you require support with, or urgent extra medication, please contact KPS pharmacy
- If you require support with IP&C advice and support please contact IP&C Coordinator at infectioncontrol@kamsc.org.au
- After hours Public Health Physician - **1800 434 122**
Any cases on the weekend will be called through from the on-call Public Health Physician. Call back this number if you need to return a call.

Additionally, KPHU has designated a Public Health Nurse to coordinate the response for the Kimberley region. Their contact details:

Marama Haenga Regional Immunisation Coordinator

T: (08) 9194 1640 | **M:** 0488 255 596 | **Confidential Fax:** (08) 9194 1631

E: marama.haenga@health.wa.gov.au

Definitions

Enter definitions of terms used in this document to help give the reader context.

TERM	DEFINITION
Case	A person with laboratory confirmed toxigenic positive diphtheria.
Contact	In this scenario, a contact is a person who has had contact with a confirmed case within their infectious period.
Diphtheria	A highly contagious, and potentially life-threatening, bacterial disease caused by <i>Corynebacterium diphtheria</i> or <i>Corynebacterium ulcerans</i> . Diphtheria usually affects a person's nose, throat, and windpipe, but it can also infect their skin. The skin infection is not generally severe, but the bacteria can spread to others and may cause the more severe respiratory form of illness. Toxigenic positive diphtheria releases a toxin that causes widespread inflammation in the body.
dTpa	Diphtheria, tetanus, pertussis – referring to combination vaccine.
Personal Protective Equipment (PPE)	Equipment which is intended to be worn or used by healthcare workers to promote patient and personal safety against infection risks e.g. gloves / aprons / eye protection / mask.
SASA	Structured Administration and Supply Arrangement – a legal agreement that allows non-medication endorsed Nurses, Midwives, AHPs and AHWs to administer medications under strict criteria.
Standard Precautions	The minimum level of infection prevention practices applied in all healthcare situations, regardless of infection status.
Transmission based precautions	Additional measures used for patients known or suspected to have infectious diseases that can spread via contact, droplet, or airborne routes.

Roles and Responsibilities

All Staff

Comply with instructions included within this guidance, and with KPHU advice as arising.

Medical Director

Oversee and coordinate outbreak response.

Public Health Registrar

Support outbreak response through contract tracing oversight, clinical advice coordination for vaccines and treatment and provide education on request.

Vaccine Clinicians

Provide support with vaccination of community.

IPCC

Provide support with IP&C and staff vaccinations.

Related Documents

The following documents are required to give effect to this policy:

- Doc_2147 [KAMS Standard and Transmission Based Precaution Guideline](#).
- Doc_2148 [KAMS Infection Prevention and Control Policy](#)
- Doc_2130 [Management of Occupational Exposure to Blood and Body Fluids](#)
- Doc_735 [Staff Vaccine Preventable Diseases \(VPD\) Policy](#)
- Doc_2131 [Management of Health Care Workers with Infectious Diseases](#)
- Doc_2245 [Poster – Standard and Transmission Based Precautions](#)

Additional Resources

KAMS Education

- Diphtheria PowerPoint from KAMS Public Health Registrar and Senior Medical Officer
[KAMS Diphtheria Review 17.4.pptx](#)

Factsheets

- [Aboriginal Health Council of Western Australia brochure](#)
- Kimberley Population Health Unit Diphtheria factsheet

Poster for Clinic

- Kimberley Population Health Unit Diphtheria Poster

Australian Communicable Disease Centre

- [National Notifiable Disease Surveillance System](#)
National case numbers and demographic information
- [Epidemiology report](#)
- [Interim Diphtheria Guideline](#)

WA Health

Case numbers by region

- [Western Australia Notifiable Infectious Disease Dashboard](#)
- [WA diphtheria outbreak case and contact management interim guidance](#)

Vaccination Resources

- [Western Australian Immunisation Schedule](#)
- [WA Health Annual Vaccine Training Modules](#)

SASAs

- [WA Health SASA Nurse Vaccinators](#)
- [WA Health SASA AHPs Vaccinators](#)
- KAMS Diphtheria SASA TBA

AHCWA Resources for Contact Tracing

- https://www.ahcwa.org.au/wp-content/uploads/2026/03/Information-for-High_Med_Low-Risk-Contacts-of-Diphtheria.pdf
- <https://www.ahcwa.org.au/2026/03/06/diphtheria/>

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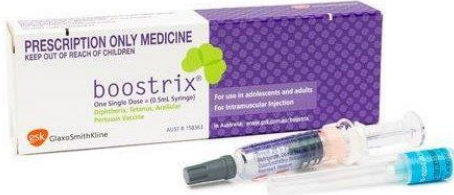
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Appendix 1 – Contact tracing sheet

Please use only if live spreadsheet not accessible.

Index Case Details					Diphtheria Type:			Toxigenic:		Date of contact tracing:		
Name: DOB:												
Date of contact	Address (if compound specify house number)	First Name	Surname	DOB	Risk cat: High Medium Low	Swabbed: Yes No Refused	Antibiotic type, dose duration	Vaccine name Yes No Refused	Batch Number	Factsheet Yes No	Vaccinators Name	Last diphtheria containing vaccine

Appendix 2 – dTpa Vaccination Cheat Sheet

Brand	Age group	
Adacel	≥10 years of age as booster	
ADT	≥ 5 years of age as booster	
Boostrix	≥ 4 years of age as booster Pregnancy	
Infanrix hexa	Infants and children ≥ 6 weeks of age primary immunization Booster dose in children ≥ 18 months	